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ABSTRACT

In terms of a dialectical model, the person-situation context is viewed as inseparable and necessarily interdependent. The very diagnostic categories used in the profession are as subject to the zeit geist as are the character structure and behavior of the individual. The evolving diagnostic categories as codified in the "Diagnostic and Statistical Manual of Mental Disorders III" (1980 unpublished) reflect the changing nature of character structure as compared to the 1952 or 1968 editions. Character structure, defense operations, and diagnostic categories need to be viewed systematically. Diagnostic categories need to take and everchanging contributions of psychological and social (role and and overchanging contributions of psychological and social (role and system) determinants of inter-personal behavior. Theories of personality and explanation of behavior formulated in other societies and under conditions unlike those of today, give a point of departure for applying the knowledge of the current societal norms, inter-personal contexts, and intra-psychic processes before giving a diagnosis. (Author)

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A VIEW OF DIAGNOSIS

Who is mentally ill in 1978? That question takes on added significance when we ask it in comparison to those who were viewed as mentally ill in 1950 or in 1900. The answers reveal a great deal about the society at the time, and the nature of the theories of psychopathology being observed.

Clinicians, on a daily basis, make decisions about who is mentally ill. With their training, experience, and intuitive sense, they administer psychological tests, conduct clinical interviews, and finally decide upon a diagnostic classification for the individual.

If the year was 1840 the choice would have been relatively simple. In this country the only category of mental illness was idiotic and insane (Roche Report, 1975). By 1880 the number increased to seven categories. In the years that followed, the nomenclature changed and was finally codified in the Diagnostic and Statistical Manuals of Mental Disorders (DSM), published in 1952 and revised in 1968. DSM III is currently being field tested and this third and major revision should become official by January, 1980.

When the 1952 edition is compared to its 1968 counterpart, one is immediately struck by the changes in categories and descriptions over the years. The new DSM III has 50% more diagnostic categories than the DSM II.

Dr. Spitzer, the chairperson of the American Psychiatric Association Task Force on Nomenclature and Statistics, is charged with the development of this document. He expressed the desire that DSM III reflect our current state of knowledge in the field. Apparently our current state of knowledge continues

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to evolve and change so that by 1980 people will be diagnosed quite differently than they are today. The question then arises as to whether these people are so different as to warrant these new titles, or are we as professionals considerably different from what we once were, and thus becoming more sophisticated in our field? The answer, I maintain, is both. Not only have both changed, but we could not have done it without each other.

What I hope to do is to briefly describe the dialectical relationship which exists between the individual and society, and the complex interaction between the two in which psychology finds itself.

The social norms and family conditions of the 1970's are certainly different from those of the 1950's and 1960's. The societal context has undergone tremendous change. Within a dialectical framework the pe son situation context, in this case the individual and society but equally true for a one to one interface, is inseparable and necessarily interdependent. This concept is not difficult when we realize that, for instance, psychiatric practice in Russia with its potentially repressive implications, is both different and abhorent to most of us. This is because we can "see" how a diagnostic system with its political ramifications is utilized by the state to control deviant members of society. We can see it since we are not entrenched in it, and we could surely write scholarly papers about the Soviet linkup of political ends and scientific means, and the resultant distortions in the sciences. It would be more difficult for us to see how the ideological and social underpinnings of contemporary democracy has its effects, albeit quite different from the Soviet model, on our own science and how we deal with deviance.

We, as a people, are entrenched in theories and perspectives which

influence our research and practice. The ideologies of our society, which involves our social, political, and economic systems, are continually at work. Yet, by widely accepted definition, ideology itself is considered a particular distortion of the social situation (Mannheim, 1936). The ideologies are one ingredient which contribute to the zeit geist, or "spirit of the times", and that spirit changes. Mannheim, in 1936 stated that, "The thought of every group is seen as arising out of its life conditions." (Mannheim, 1936, p. 78). The thoughts of Sigmund Freud were an outgrowth of the Viennese zeit geist of the turn of the century.

The conversion hysteric emerged from a sexually repressive society and Freud's theories were developed within this context. It was then his theories, which, in a reciprocal way, helped to influence the zeit geist.

The same symptomatology and theoretical development by necessity had undergone changes in pre and early Nazi Germany where Wilhelm Reich developed his theory of character structure. A society becoming highly militeristic and developing genocidal theories and an ubermench mentality places Reich's "Armor plating of character" theories within a political and social zeit geist which Freud's 1900 Vienna never experienced. Yet Reich built his theories upon Freud's earlier works. He was able to apply that knowledge to his particular context under that particular zeit geist.

This historical perspective may help us to understand that we too are operating within our own zeit geist and that our choice of nomenclature, which will determine who is mentally ill, arises from our life conditions. Our choices of what is pathology help influence and create our contemporary society, but our choices are also a function of the times. What needs to be

understood and emphasized is that we, byt necessity, use a distorted reality of ideology and zeit geist to make grave decisions regarding who is seen as mentally ill.

The current draft of DSM III, which again will be the official nomenclature of mental disorders in this country, is being drawn up by a committee of 15 people, 11 of whom are psychiatrists. It should therefore be of no surprise to learn that the medical model persists and has become even more pronounced in the nomenclature. We will once again be asked to define emotional problems arising from marital conflict, alienation, or dehumanization as a disease. While this in and of itself is not new, its reaffirmation at a time when third party payments and national health insurance are being debated, makes it all the more important. In other words, current economic issues are playing a large part in the formation of diagnostics.

Reimbursement cannot be made without the individual being diagnosed as being pathological. The realm of pathology is encompassed within the DSM, thereby forcing clinicians to select from the current crop of disorders before insurance companies will pay the bill. Those who were diagnosed as being neurotic in previous years will have to be re-diagnosed in order for the bills to be paid, since neurosis is not to be found in the DSM III.

Certain diagnostic categories have been debated for inclusion in DSM III which seem to directly reflect our contemporary zeit geist. Under Personality Disorders, we now have the new category of the Narcissistic Personality. This is not to suggest that such a disorder didn't exist years ago, but that the phenomenon appears to be on the rise and our level of knowledge appears to be increasing, thus making way for the identification of a phenomenon which

may have been subsumed under other titles in previous years.

The Viet Nam War, the women's movement, and the issue of gay rights, all had an impact upon DSM III in way which are probably unique to our place in history.

A group of Viet Nam veterans lobbied for "Post-Vietnam Combat Disorder" with its implications for third party and government payments for its treatment. Various women's groups were influential in changing the category "Sexual Sadism" with its implications for excusing rapists as not being responsible for their acts. Homosexuality as a disorder was dropped from later printings of DSM II after the 1974 vote by the APA. In various drafts of DSM III we now find "Psychosexual Distress Disorder" or "Homosexual-Conflict Disorder", thereby limiting mental disorders to only those who are distressed because of their homosexual arousal.

Here again the point is not the correctness or the validity of these influences, but the mere fact that they happened. The norms of society are both influencing DSM III and will be further influenced by this document in a way which is unique to our time. These categories emerge as a result of various influences which preceeded it; for example, the social, political, and economic impact of the 1960's and 1970's, and events which are anticipated, for example, national health insurance in the 1980's. The uniqueness of these influences upon contemporary values are reflected in the changing theoretical views of our time, for example, the outpouring of publications on the Narcissistic and Borderline disorders, and ultimately in who is considered mentally ill.

The point that continually comes through is that a diagnosis is not a thing. It is not a physical entity, but an ever changing abstraction. That is how we can account for 50% more categories in DSM III than in DSM II. And this changing abstraction is not just in nomenclature, it is part of our relationship with the person. We readily speak of decompensation, re-integration, pre-morbid personality, etc. which recognizes dynamic as changing. Why then do we hold on to diagnostic impressions as if they are carved in stone? We must recognize that this "thing" called diagnosis is actually a process which need not have universal agreement. The phenomenon just cannot be viewed apart from its contexts; be that the societal or the interpersonal contexts. The assumption tends to be that the clinician is a non-specified yet consistent given. The reality is that the clinician reacts differently to people. Thus, the clinician is changed in the process of diagnosis.

It would be ludicrous to expect a person to behave in the same way and thus to be diagnosed identically by diagnosticians of various sizes, shapes, and colors. People will interact differently with different people. One cannot be equally empathic, genuine in feeling, and uncritical of all others. People interact differently even with the same client.

The different impressions gleaned by various interviewers, for instance in a clinic setting, need not be seen as issues for debate or for a decision on a differential diagnosis. They may all be correct as seen from a unique vantage point, which again need not discredit another person's impressions. That would only be the case if a diagnosis were a thing a person had.

Dr. Spitzer, in explaining the disappearance of Involutional Melancholia from DSM III, recently remarked that, "There is no evidence of its existence."

(Roche Report, 1975). Those poor clinicians who now have to rethink all those erroneous diagnoses they have made, all the time having thought that their patients had something that now no longer exists! But how then do we explain the inclusion of such items as "Tobacco Use Disorder" under Drug Use Disorders, or "Caffeinism" under Drug-Induced Organic Mental Disorders? Is it possible for a document to be so over zealous and all inclusive so as to exclude few if any of us from being called mentally ill?

This very well may be the case with DSM III, but if so it should serve as an important ingredient if this document were to be placed into a time capsule. It is a reflection of and influence upon our society in general and our profession specifically, which will tell some future generations a great deal about who we are and what we are about, and who was to be considered mentally ill in the 1980's.

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